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The Future Health Worker

Regulation of Health Care Assistants

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Executive Summary

Patient safety has become a key issue for policy-makers, fuelled by concerns about medical malpractice, the growing number of legal cases and the rising costs of insurance, as well as apparent falling public trust in health care providers. Yet despite the increasing stringency that we are now seeing over continuing professional development, re-accreditation, protection of children and vulnerable adults, and inspection of social care providers – these measures have yet to have a direct impact on the employment of the majority of staff within the NHS.

This paper reviews the possible future requirement to bring in some form of regulation for non-professionally qualified generic support workers in the health services, otherwise often referred to as Health Care Assistants (HCAs) or Health Care Support Workers. It sets out a case for greater regulation, based on the risk involved in non-regulation, the changes we are seeing in roles and skill mix and the benefits regulation might bring for HCAs themselves. It goes on to review the case against regulation, stated in terms of possible costs, lack of evidence of necessity and alternative ways of achieving desired aims. The paper then sets out a range of different forms of regulation and considers the issues involved in implementing different levels of quality assurance and risk minimisation.

Background

It would appear that the regulation of health and social care professionals is set to undergo further tightening. High profile cases of poorly performing professionals (Shipman, Ledward, Bristol) have contributed to a climate where this is seen as both necessary and unavoidable.

Many of the reforms undergone by regulatory structures have sought to replace traditional reliance on trust and self-regulation. The General Medical and Dental Councils have been required to reconsider and reform their regulatory systems and the Royal Colleges are playing a new and increasingly interventionist role in validating professional education. The Nursing & Midwifery Council has replaced the UKCC (United Kingdom Council for Nursing, Midwifery and Health Visiting) and the Health Professions Council replaces the Council for Professions Supplementary to Medicine (which was limited to overseeing no more than 12 such groups). The new Council will recognise and oversee new professions as they emerge, as in the case of Paramedics. Over all these bodies will be the new UK Council for the Regulation of Health Care Professions, which will have a much enhanced ‘lay’ (non-professional) representation.

These developments occur within a wider political and social context. Allsop & Saks (forthcoming 2002) list a number of important changes occurring at the turn of the century connected to the fact that ‘public trust in some traditional professions had declined, although there was still no significant fall in the demand for professional services’. Concern with public safety and concurrent regulatory reforms are also not limited to the medical world. Church officers, including those elected by their congregations as well as ministers and ‘Sunday School’ teachers, are being submitted to checks on the Home Office Child Protection Register and the net is widening.
At the same time, despite demands for quality control at the ‘top end’ of the hierarchy and in the voluntary sector, Health Care Assistants or ‘Support Workers’, who work alongside professionals and across domains or specialisms, often without formal qualification and generally under the supervision of a professional, are providing an increasing proportion of care. This diverse group remains wholly unregulated. None of the regulatory reforms mentioned refer explicitly or overtly to the management or licensing of HCAs, although the new president of the NMC has reportedly stated that he feels it might be appropriate for the NMC to play a significant role (Nursing Times 2002).

It might well be anticipated that any services involving, or permitting, access to people’s homes and bodies would require some form of regulation or control in order to assure predictability and certain standards of service (based on skills and behavioural norms) and thus protection to potentially vulnerable people. These notions were acknowledged in the post-1997 NHS Plans. An independent review of the Nurses Midwives & Health Visitors Act, carried out by JM Consulting in 1998 explicitly recommended that the Government should undertake a further study to examine the role of support workers employed in health care settings (JM Consulting 1998). At present, however, HCAs in the health service are not covered by any form of regulation (other than common law) in any of the component parts of the United Kingdom, although there have been changes in respect of those working in social care settings.

Despite the submission to the four Health Departments of the UK of a report into Health Support Workers (conducted by a team from De Montfort University in 2000), no actual changes have occurred in relation to the regulation of HCAs. This paper explores some issues and possible ways forward.

The cases for and against regulation

If we are to discuss the ‘best way’ of regulating, it is also necessary to ask why regulation is necessary, and whether it can be justified on pragmatic grounds.

Sceptics of the case for regulation may point out that there is little evidence of ‘harm’ arising from the employment or activity of HCAs. They may, with justification, point out that cases involving Health Care Assistants that have hit the news seem largely to have been those in which a Health Care Assistant was abused or harmed by a registered professional, usually in a supervisory role. One recent case was identified where a HCA abused his position of trust in forming a sexual liaison with a young woman (who had a learning difficulty) - but it seems likely that this would now be covered by other regulation relating to those working with children and vulnerable adults.

Flowing from this argument are several proposals: first, for greater onus on inspection of providers rather than the development of systems of regulation and, second, for an in-depth assessment of the opportunity costs of regulation. There are several potential opportunity costs involved in the regulation of non-professionally qualified staff.

A bureaucratic and delaying regulatory procedure might lead to the loss of valuable recruits who need encouragement rather than obstacles put in their way of enrolling as
a Health Care Assistant. Compulsory registration could also professionalise the role of HCAs and as a result, put upwards pressure on wages, thereby taking money out of the health / social system. This has the potential to result in a lowering of the standard of health provision.

If there are doubts about whether or not the opportunity costs exceed the value of the benefits of regulation then it could be argued that, in the interests of optimum risk management what is required is a reflective rather than a prescriptive approach. In the short term one would need to assemble information on the level of risk that certain groups pose to patients, before rushing forward with immediate policy solutions. The ideal would be if information could legally be obtained (in an anonymised form), from the police service on those HCAs who have any form of criminal record. It would then be possible to create a regression model looking at the relationship between different previous criminal records, and any subsequent conviction for abuse in any HCA role (the dependent variable).

Information from the regression analysis could then allow us to see precisely which groups of individuals represent an unacceptable risk to patients. The advantage of this approach to regulation is that it assists intervention when it is appropriate, rather than universal, flat-rate regulation that prevents the supposed threat of a 'paper tiger.'

The case for regulation

On the other hand, there clearly are risks, not least of which is the danger that someone who has been struck off, or dismissed from a post (or training course) because of incompetence or misbehaviour may re-invent themselves or find employment as an HCA ‘below the radar’ of professional regulation. Anecdotally, such cases certainly exist, although they do not seem to be widely reported. Similarly, if such persons are ‘allowed’ to resign, and are not formally proceeded against, then adverse event reporting will not take place, and no record will exist for the benefit of potential future employers.

In many ways, this is a feature of the current legal framework. Price (in Allsop & Saks 2002) notes that the House of Lords Select Committee on Science and Technology in 2000 observed that there is a “common law right to practice medicine (which) means that in the UK anyone can treat a sick person even if they have no training in any kind of health care whatsoever, provided that the individual treated has given an informed consent”. However while you may treat, you must be careful how you describe yourself and your actions: titles are protected, as are rights of prescribing. This contrasts with the principle encapsulated under Belgian law (Article 37 of the Law on the Practice of Medicine) which stipulates that “it is an offence to carry out in an habitual way an act or acts that belong to the field of medicine without holding the required diploma” (or a legal exemption). In the UK it is only Midwifery and Dentistry that have similar protection (except, naturally, in emergency situations). In general, functions are free of regulation, but titles are not. This is entirely consonant with the ambition of the NHS Plan (2000) to increase flexibility of working by allowing those trained under existing professional titles to broaden the range of responsibilities that they hold or skills they develop through the course of their career. Indeed, the Health & Social Care Act 2001 is giving wider powers to prescribe
(notably to pharmacists) and for delegation of responsibilities from registered nurses to HCAs.

The problem with this is that those struck off the register could theoretically re-invent themselves under some unprotected title (such as cranio-maxillo manipulatory therapist) and set up in private practice with no bar to them. The only activity specifically restricted by law to registered practitioners (midwives etc) (except in emergency) is ‘attending a woman in childbirth’. Otherwise, the majority of protection is afforded by restricting the right to offer services under a specific job title – such as ‘Registered Nurse’, Osteopath or Chemist (terms restricted in law to registered practitioners).

This last point raises one other argument in favour of some form of regulation: that the process itself may protect not only the public, but also the practitioner. Regulation may provide a way of guaranteeing the good name of a trade or profession, and may also provide links to qualifications, training and personal/professional development, giving recognition to otherwise nameless workers for what they do – by naming them. It might also protect workers from litigation by defining the limits of what may be expected of them and recording that they have been given adequate training.

**Current context**

The Royal College of Nursing has considered the issue of regulation for non-professionally qualified staff at some length. It has welcomed some HCAs (those with NVQ level 3) as members, although these members can not be Chair of a Regional Board or stand for election to the RCN council. Other professional bodies such as the College of Occupational Therapists and the General Dental Council have also elected to bring HCAs into their membership. In all cases, it seems that members of the professions have felt that there were benefits to be had from increasing regulation, and from admitting their currently non-professionally qualified colleagues to some form of membership of the representative body, whether as Occupational Therapy Assistants, Dental Nurses, or HCAs.

The recent RCN Congress (2002) debated the issue of regulation and passed a motion by a clear majority (70:30) in favour of standardised NVQ training, clear role boundaries and a national regulatory framework. The debate hinged on issues of ‘role creep’ - as nurses took on new functions and HCAs increasingly undertook nursing care. The consensus of opinion appeared to be that HCAs should be brought under the authority of the new Nursing & Midwifery Council (NMC), or, depending on setting, the Social Care Council, and the whole process unified. This was also seen as implying better training and career opportunities for HCAs.

From the wider perspective, this raises the problem of splitting the HCA/Support Worker regulatory process into at least three sectors since not all non-professionally qualified staff will fit under the rubric of the NMC or Social Care Council. By definition, many HCAs will work across all those sectors and there are strong reasons to suggest that, within a climate of increased flexibility of workforce roles, existing professional silos should not be reinforced (see Rogers 2002).
The overwhelming contextual issue remains the chronic reported under-recruitment of staff to the NHS and the attempts to move role boundaries among the ‘higher’ professions. Shortages of doctors in hospital and general practice have led to the introduction of Nurse Consultants and Nurse Practitioners. To meet a growing demand for specialists and professionals new career and educational structures have developed, new ways of moving into (and out of) nursing, accelerated late-entry routes into new courses and medical schools. As nursing has become increasingly a graduate profession, new step-on step-off training ladders and attempts to attract new sources of workers into the profession by introducing innovative routes of entry have emerged. Many of these create, for a part of the individual career, new types of HCAs until they reach a level of competence and qualification to be recognised and registered as fit to practice under the professional title. At the same time, there are pressures to change skill-mix and examples have been published where doctors run between examination rooms while patients are ‘prepared’ by unqualified HCAs (GP Newspaper 2001). In hospitals, by the same token, ‘healthcare practitioner assistants’ have been proposed to do ‘a broad range of support work’ (Cochrane et al. 1999).

It is also possible that moves towards ‘professionalisation’ reduce flexibility and require the accretion of people who ‘can do’ those tasks, rather than encroaching upon valuable time required for professional updating and personal development. In other words, by insisting that public protection and clinical governance require greater specialisation and higher levels of specific skills, the pressure to have a unqualified (but supervised) worker who can be asked to do a wide range of tasks increases.

Defining a HCA

There remain serious problems in defining who constitute the Health Care Support Workers (HCSWs) or Health Care Assistants (HCAs) workforce. Despite considerable discussion, there is no simple, agreed or legal definition of this category of worker. Almost by definition, they defy description in simple terms and hence enumeration (see also Rogers 2002). Here, we limit our discussion to those who are employed rather than voluntary carers and who are not professionally qualified or regulated. It is possible, within these limits, to identify several categories of employees.

Health Care Assistants in many cases work in ‘generic’ rather than specific, skilled roles providing direct personal care in health care settings, and not requiring complex or specific skills. Some of these may be nurses or medical students in training before becoming licensed to practice autonomously, for money. The term is also used to refer to non-professionally qualified workers such as Nursing Auxiliaries or Occupational Therapy Assistants for example, who work in support of a particular profession or professional team. HCAs, strictly defined, should perform devolved tasks under close supervision and tasks that might compromise clinical duties (e.g. removing unhygienic materials in an operating theatre during an operation). In reality, there is convincing survey evidence to suggest that HCAs perform tasks that bring them into direct contact with patients without close supervision by registered nurses (Thornley 1997, 1998).

A further set of HCSWs are the ‘emergent professions’ or cadres of staff undertaking health care roles that have yet to be recognised as professions. An example frequently
given is that of Operating Department Practitioners and Medical Technical Officers or Paramedics, some of whom have now been subsumed into the regulation of the Health Professions Council. This process is likely to continue as new roles or technologies develop. Some of these roles (notably the Operating Department Practitioners, now given higher status and responsibility) still necessarily have supervisory responsibility in respect of HCAs, as Paramedics may also supervise Ambulance Care Assistants.

Another group that might be seen as an ‘emergent’ profession, are those who provide complementary or alternative medicines and therapies. A recent BBC radio broadcast (You & Yours 14/6/02) suggested that there were more than 60 complementary therapies on offer, and that the British Complementary Medicines Association estimated that there were over 100 bodies claiming to register practitioners. There is no single body to assess qualifications or assure national occupational standards, even if hakims or vaids working largely among the minority ethnic populations may have very well established professional traditions on the Indian sub-continent. Of the ‘alternative’ therapies, in the UK only Osteopaths and Chiropractic practitioners have a formal and legally based regulatory structure (with protection of the use of the title). Herbal medicine and acupuncture are currently being examined by government agencies and may eventually be brought into a similar sphere of control. In view of clinical papers reporting on the potential for adverse effects from some products (notably Chinese ‘herbal’ formulations) and the potential for fraud, there is clearly some potential for a case to be made for more public protection than is provided under ‘caveat emptor’ (let the buyer beware).

A further group may be described as autonomous or flexible workers in the community, group or social care and domestic settings, such as rehabilitation assistants or domiciliary care workers. These often overlap with ‘social care’ assistants, and may perform both health and social care roles in the same or different settings. They may be the same as, or work alongside, directly employed (non-NHS) personal assistants. In addition to these, there are significant numbers of staff employed directly by service users, sometimes with direct payments from health and social care agencies or out of Attendance Allowance payments.

Finally, and not perhaps easily or necessarily defined as health care support workers in the same sense, there are others working in or alongside health care settings who may ‘step out of role’ from time to time, or perform tasks which are essential to health care and include some of the same functions and actions. In this we might include clerical and technical support staff, ambulance and hospital car drivers and ward clerks.

Some estimates of the numbers of different HCAs and HCSWs, and a comment on training needs identified among paid carers, are given in the Appendix 1 to this paper.

The wider context

Globalisation and devolution

It is important to note that the employment of health care workers in the UK does not take place independently of events and agreements elsewhere. In particular, the Single European Act and agreements under the various conventions covering the operation of the European Union affect the freedom of action of governments and employers in
health. In particular, the processes of Harmonisation in respect of professional services means that sectoral directives cover exchangeability of professional qualifications for doctors, dentists, nurses, midwives, pharmacists and vets within the EU, under freedom of movement regulations. We have referred to Belgian laws restricting certain rights to practice, above, but were unable to locate any reliable source of information relating to regulation of HCAs in Europe. We are advised that there are at present no plans for this, however.

More significant, perhaps, has been the recent countervailing trend in the UK, towards devolution, the creation of the Scottish Parliament and Welsh and Northern Ireland Assemblies, with rights and privileges attaching to them. Quite explicitly, the question of professional regulation was not devolved, but matters such as the mode and quality of service delivery and care issues are. Nevertheless, in the short time since these bodies were set up, there have been some significant changes or steps taken which have widened the gap between the constituent regions or territories of the United Kingdom. Furthermore, there are differences in the educational provision, with Scotland having SVQs (Scottish Vocational Qualifications) while Northern Ireland, Wales and England at present use a common structure of National Vocational Qualifications (NVQs) with a common agreed set of standards and curricula. There is clearly potential at least for increasing divergence in the content of these, even if (at present) there is no mandatory requirement for HCAs to have any level 2 or level 3 awards in health care (or any others). At present, for example, the development of Nurse Cadet schemes is most highly progressed in England, where they tend to be locally agreed schemes agreed between local NHS Trusts and local universities. For those people who do not proceed to the full qualification, a new category of HCA will be created.

While ‘current regulatory bodies’ (and regulations) are reserved to the Westminster Parliament, it is pointed out (RCN website) that the Scottish Care Council (created by the Scottish Parliament as from April 2002) will regulate health and social care staff working in registered services. That same Parliament would have to agree to any changes or extensions in the remit of existing UK national regulatory bodies such as the NMC, should it wish to take on responsibility for HCAs. Similarly, it is reported that a recommendation has been made to the Welsh Assembly that the new Welsh National Board should have a quality assurance role in the training of HCAs in health care settings. The case in Northern Ireland is complicated by the need to ensure that ‘cross-border’ working arrangements are not compromised.

We summarise some of the key organisational differences between the constituent partners of the UK which may have a bearing on the future regulation of HCAs:

* In Scotland, care homes, domiciliary care, adoption and fostering and early years education will be regulated by a Scottish Commission for the Regulation of Care

* In Wales, the functions of the National Care Standards Commission will be undertaken by the Welsh Assembly and a Children’s Commissioner for Wales.

* Northern Ireland has a separate Ombudsman for Health & Government
The Commission for Health Improvement (CHI) and National Institute for Clinical Excellence (NICE) operate only in England and Wales: in Scotland the equivalent functions are undertaken by the Scottish Intercollegiate Guidelines Network, Health Technology Board for Scotland, and Clinical Standards Board for Scotland. Arrangements for Northern Ireland, where health and social care services are managed together rather than separately, are still being discussed, in the form of a Health and Social Services Improvement Authority.

While these structures are still emerging and changing, it is difficult to discern their implication for the future of regulation. Clearly, the most important thing will be to take account of the need to ensure portability of status between national settings, and also to ensure that national regulatory systems ‘talk to’ each other to ensure that mobility does not permit evasion of controls for those who do so maliciously.

Towards a learning culture?

In setting out the wider context for regulation debates it is also relevant to mention that, alongside a trend towards reform of professional-self regulation, runs an attempt to promote a more open, ‘no-blame’ culture within healthcare organisations as part of attempts to create a learning culture.

The prospects for success in this area are somewhat unclear. In future, data on adverse events will have to be submitted by Trusts to the National Patients Safety Agency, as part of the clinical governance requirements. However, those responsible for carrying out research in this field comment that currently the reporting and recording of both complaints and adverse effects is poorly managed and incompletely investigated in many agencies. Lessons are frequently not learned even within Trusts, and there is little sharing of ‘critical event’ analysis locally or nationally. There has been some move towards this within General Practice, where it is seen as ‘Good Practice’, but it is suggested that proper implementation of this sort of approach will require instigation of no-fault compensation and a ‘no-blame’ culture to encourage openness in reporting and sharing of lessons learned. This might also have to be coupled with greater ‘activation’ of consumers, being encouraged to make complaints and challenge poor performance. This will, naturally, be resisted by the professions at present, and requires the concept of an agreed level of a standard of service against which to measure the reasonableness of a complaint.

These themes enter into the debate about HCA regulation since proper response to adverse incidents would require regulation that set, and publicised, standards which might be expected from those using (or receiving care from) various levels of staff and this would include HCAs.

Regulation, registration and other safeguards

Bearing in mind that the case for regulation is not necessarily proven, yet appears persuasive in the light of trends towards alterations of skill-mix and concern with patient safety, the following section describes a range of regulatory measures that could be adopted.
There are, already, a number of levels of regulation and protection arising from the 1999 Protection of Children Act and 2000 Care Standards Act. These have caused the establishment of lists of those who are (deemed) unsuitable to work with children and vulnerable adults. They require employers to report adverse incidents to the Secretary of State for inclusion on this register – and care providers have a statutory duty to carry out checks before offering employment. However, there remain weaknesses even here: while it is expected that this covers agencies (under their duty of care) it does not prevent private hirers hiring openly, nor necessarily provide them with a channel to make enquiry of the registers. Nor, indeed, does it cover the case of the person who gives a false name or other personal details. Further, regulatory agencies do not have rights to control those without registerable titles or registerable qualifications.

It may, of course, always be argued that those who are not registered and do harm others, could be liable under common law for assault or some other tort. Yet this remains a post-hoc way of obtaining some sort of remedy and does not answer the question of prevention, nor of ensuring that repeated harms to not occur.

This discussion would seem to assume that the core activity or function essential to regulation is the setting up and use of a Register. This has certainly seemed to be the dominant focus of most discussions and documents reviewed. It is therefore necessary to insist that there are several central components to regulation, not all of which depend upon the existence of a register. These are, for simplicity:

* Service Standards
* Occupational Standards
* Agreed Competences
* Supervisory Arrangements and Responsibilities
* Opportunities for Educational and Career Development
* Exclusion of known risky individuals

Many of these, in particular the first three, should be independent of any registration process and might be thought to be precursors of one. Service Standards, Occupational Standards and competences are still underdeveloped, and dependent upon a set of agreed definitions, to which they would contribute or relate. As already discussed, the perception amongst employers is that HCAs represent a cheaper source of labour than professional staff and have the advantage of being able to work across a number of areas of competence based on some notion of a basic subset of generic common-sense abilities and skills. Regulation would require the agreement of all stakeholders (users, employers, professions) as to the nature, level and limitations of these flexibilities.

Supervisory arrangements and the exclusion of known risky individuals, might be thought to be covered by the existing procedures for the regulation of professions and employment more generally. These include the general duties of care, the principles of professional practice in each profession as laid down by their individual governing bodies, and the over-arching regulation of services and individuals in legislation. Clearly, this might be facilitated by a register, but that would not be a necessary element.
Finally, and perhaps most controversially, is the question of career development, continuing professional or educational development, and protection of the rights and interests of the support worker him or her-self. This is the reason why it is often reported that the most enthusiastic supporters of regulation are the staff who would be affected themselves and why there remains some doubt as to the economic cost and value of introducing a formal system of regulation (see below). Clearly, any move to ‘name’ and recognise the roles of HCAs will bring attention to bear on their own terms and conditions of service and training needs – even without a register.

However, since the concept and use of a register has dominated all previous discussion about regulation, it is necessary to examine what might be the options in setting up such a structure.

**Possible models for development of a register**

It appears that, in view of the problems currently being experienced by the transfer of responsibilities from the old English National Board (ENB) to the NMC, which is reported to be overwhelmed by the size of the task of registering over 600,000 staff, a ‘big bang’ approach setting up a new register from scratch may not be feasible. It will therefore be essential to ‘grow’ any register if that is seen as central to regulation. It is likely that, in the beginning, this will need to be designed as a minimalist exercise. It is also likely, in view of the problems of definition alluded to earlier, that the first phase might seek to distribute responsibilities for groups which can be devolved to other regulatory bodies – so long as those boundaries can be defined unequivocally.

After ensuring that assistant staff who have specific functions and relationships with existing regulated professions (as with operating theatre assistants, dental nurse/assistants) are regulated by the professional regulatory body, there will remain a significant number of health and social care workers who operate with ‘generic’ skills. These, by definition, cannot be defined and regulated on the basis of specific qualifications or abilities. They will, therefore, necessarily have to be ‘managed’ by a simple process of registration – which initially could be voluntary and self-financing. Such a register, being voluntary, could be self-financing, managed by a joint board under the authority of the Nursing & Midwifery Council, and the Social Care Council and the guidance of the Council for Health Regulators. In view of the pay rates of most HCAs, fees would have to be low in order to be affordable.

**A code of practice**

A core element, and a key issue in the question of ‘self-regulation’ and professionalism, is the assent of members of a group to some agreed code of practice or code of conduct against which they can be disciplined. Inclusion of one’s name to a register would imply explicit acceptance of whatever code (like the so-called ‘Hippocratic Oath’) might be devised. Clearly to have a code without explicit evidence of assent (such as a signature) would be fairly meaningless.

At its simplest, this could operate as a light-touch system and pave the way for a more structured arrangement once the majority of workers (or potential employers) had taken advantage of the voluntary register and found it to be of value. It would also
enable piloting of the system and avoid expensive and embarrassing backtracking in the event of the problems that might arise through omission or commission.

A ‘Negative Register’

An alternative minimal register would be a ‘Negative Register’ which simply recorded, as does the Home Office Child Protection register, those who are known to have caused harm or be likely to do so. This would require consultation with the data protection authorities (probably at a European level) and the bringing together of NCIS (the national criminal intelligence system), the Home Office and local police registers of child abuse and those notified under regulations relating to protection of vulnerable adults. Ideally, such a register would contain key employment data such as date of birth, National Insurance or NHS numbers to facilitate checking and reduce concealment, since these data could be verified against other employment functions such as taxation. To this would be brought evidence or reports of ‘striking off’ or serious disciplinary action against any members of one of the existing registers of professional bodies, including the CNM and GMC, and also voluntary registers such as those of the College of Occupational Therapists and National Carers Register.

In order to protect individuals, it may be necessary that such a register be not made widely available through publication, as sex offenders are presently protected, but it should be possible for it to be checked by bona fide employers at least for ‘exclusion’. An appeals mechanism would also be required, possibly through some form of ombudsman, and data verification by those who think they may be on the lists.

A Record of Competences

A Mid-Protection register would add to the above, but could also develop incrementally, and include a variety of levels of information. Entry to such a register could be dependent on, or merely ‘record’, certain key core skills and whatever qualifications (NVQ from level 1 upwards, for example) might be held. References might be requested or entered into the file, and in cases of doubt, an interview process set up to validate or confirm details. Such information would be updated by an annual or biannual re-registration that would include provision to supply details of employment or other information about the work record of the individual.

Termination of registration would then depend on a complaint system, initiated by employers who would have to have a responsibility to notify the Register of dissatisfaction, as they would have a right (or, eventually, responsibility) to check the register to assure themselves of the credentials of applicants for work. Again, procedures to manage data, update, verify and deal with appeals would be required.

A Maxi-Register

A Maxi-register of Approved Workers could grow from the above, and might include (for example) a ‘PIN’ number, smart card, or world-wide-web accessibility and links to professional registers so that all health and social care workers could be traced and tracked to their appropriate levels of registration and competence. Data would include recognised qualifications, adherence to agreed occupational qualifications, work experience and even accredited ‘prior experiential learning’ (APEL) in a curriculum
vitae format. While this might fit with the notion of a ‘skills escalator’ and a seamless set of occupational standards and professional competencies, it will require a high level of agreement over qualifications and experience, regularisation of occupational titles and role boundaries. This is unlikely to occur soon.

**Conclusion**

It would appear that the introduction of new forms of regulation and control over the activity of HCAs is inevitable. This would be in keeping with the trend for all other health care staff. It is important, in such a case, to pay careful attention to the impact this will have, on the workers themselves; the labour market; the conditions of service and prospects in terms of costs to service providers and commissioners. It will also have implications for the service as a whole if it affects the possibility of flexible working and service provision dependent on particular types of staff availability. This suggests that consideration will need to be given to alternative approaches, such as a graduated or ramped introduction of controls and standards, the adoption of minimal model registration model and the alternative of greater inspection and regulation of service providers, not tied to regulation of individual staff workers. In all cases, some greater consistency in the use of occupational titles is in the interests of all concerned.
References and Acknowledgements

The paper has drawn extensively on material in a forthcoming volume:


Department of Health (2000) *A Health service of all the talents: Developing the NHS Workforce* London: TSO

GP Newspaper (Dec 2001) *See Double the Patients* Volume 7 2001


RCN website (debates from Congress 2002): www.rcn.org.uk


Jonathon Ashbridge (President, NMC) quoted in *Nursing Times* (28 March 2002) “as a personal view it would be quite appropriate for a large number of those working in support of nurses to be regulated by the same organisation … We would have to devise rules and standards … before somebody would be licensed”
Appendix 1

Given the problems of definition and the multiplicity of occupational titles in use, it becomes a non-trivial task to estimate the numbers involved in working as Health Care Support Workers or HCAs. We have identified, from a variety of sources, over 300 such ‘jobs’, some of which are included in the annual NHS Workforce Census returns. Our best estimate is that there are in the UK at least one million workers employed in commercial or statutory sector posts (i.e. excluding voluntary sector agencies) which could be legitimately described as HCAs. These include, inter alia:

- Nursing Auxiliaries (circa 110,000)
- Occupational Therapy assistants (circa 5,000)
- Dental Nurses (circa 60,000)
- Local Authority Domiciliary Care Workers (circa 70,000)
- Local Authority Residential Care Assistants (circa 46,000)
- Independent Sector Residential Care Assistants (circa 100,000)
- Care Assistants in Nursing Homes (circa 102,000)
- Complementary Therapy practitioners (estimated 60,000)
- Phlebotomists (estimate 2,000)
- Ambulance technicians and care assistants (circa 13,000)

Appendix 2

Paid carers in independent residential and nursing homes

Information from the Local Government Management Board, Independent Workforce Survey (1996) indicated that 48% of staff were full-time and 52% part-time, plus approximately 250,000 volunteers. Only 32% of full/part-time staff had any qualification. Of those with qualifications 22% were in nursing, 7% had NVQs, 5% were classified as ‘other’ qualifications and just over 4% had NVQ assessor status. An estimated 14% were studying for qualifications, mainly NVQs. The government’s aim to have formally trained 50% of carers by 2005, still leaves another 50% untrained. The falling number of younger age groups (aged 16-34) and increasing number of older age groups projected to rise until 2021 (ONS) suggests that there will be fewer young people willing to enter care training programmes, especially in view of other government initiatives to encourage the uptake of higher education at university level.

Forty-one percent of residential homes and forty-five percent of dual registered residential/nursing homes reported a need for training. Current training material in the UK relies largely on printed and video material and only one UK company offers ed-rom material for Accident & Emergency care. Few organisations offer training accredited by the Health & Safety Executive. First Aid qualifications are held by only 8% of staff in all homes in Great Britain, an important element of knowledge for HCAs. There is no reason to suppose that First Aid qualifications in the general population are any higher, and indeed they are probably lower, although annually the Red Cross train 200,000 people in First Aid, and others obtain training through the Royal Life-Saving Society which includes elements of ‘life support’.
Appendix 3 – Case studies from three other areas of service provision:

Paid carers working in health and social care, especially those involved with care of older people.
The question of workers providing care in the community, especially those involved with care of older people, highlights some of the issues raised above. A study looking at information sharing across health, social care and the voluntary sector in the provision of care for disadvantaged clients and patients is ongoing (Biggerstaff, Szczepura & Roberts, funded by the Department of Health). In this, Health and Social Care staff were asked to give their job title as part of a large-scale research study. Phase one surveyed health and social care staff, management and carers (N = 634) across one defined area (to include the community trust, all the general practices for that Health Authority and the corresponding social care area). For those respondents who defined their jobs as paid carers over twenty-five different job titles were given. There is considerable job description overlap for workers providing care, and who are not likely to belong to any regulatory body. These job titles include:

Community information helper, customer advisor, care team leader, care assistant, social care assistant, home care assistant, home care supervisor, care home assistant, home care officer, care officer, community care officer, nursing home carer, nursing home care supervisor, day hospital carer, day hospital supervisor, day hospital assistant, nurse auxiliary, health care assistant, community support worker, mental health support worker, mental health care assistant.

Mental Health, Psychology and Counselling
Mental health support workers may provide additional support to mental health services provision (e.g. community psychiatric nurses (CPNs), counsellors and psychologists). The British Psychological Society (BPS) is currently reviewing their own professional regulatory system, which already has a Code of Conduct, Ethical Principles and Guidelines (see BPS website). At the present time anyone may describe themselves as a Psychologist or Counsellor, even if unqualified. The Society is seeking to rectify this, in consultation with House of Commons Select Committee (The Psychologist, 15, no 6, June 2002, p. 315). However, even for those qualified as psychologists, membership of the BPS is not compulsory for all areas of psychology. The field of health psychology has become a distinct area of psychology, separate from clinical psychology. Health psychologists have some areas that are related to clinical psychologists (see Health Psychology Update, June 2002). Within NHS management and PCTs there is an identified need for recognition and better understanding of these differing professional identities within the field of psychology for proper resource allocation and appropriate utilisation of services.

Midwifery
The UK midwifery press has begun also to discuss the idea of using midwifery support workers (e.g. for when women in labour in hospitals are left unsupported). This is based on USA/Latin American (and other cultures) usage of the idea of 'women as expert' in childbirth (sometimes referred to as 'dolor') and representing an alternative view to the medicalisation of childbirth etc. This may conflict with the current legal situation, although at present these workers will be regarded as under the direct supervision of the registered Midwife, and thus their responsibility.